SERVICES TRANSITION PLAN

Individual's Name: _____ Care Coordinator: _____
Client ID#:_____ Date of Plan:_____

Current Service:
☐ Residential Treatment ☐ Supportive Transitional Drug Free Housing

This plan is designed to transition the ATR client into a lesser restrictive, more recovery supportive services plan of care. Only those services that are anticipated to be discontinued or modified due to the newly established client cap should be listed.
FAX completed form to DBHS at 501-686-9182/Attn: Dr. Laurence Miller

Client's Identified Need	**Current Services Provided through ATR**	**Amount of Funds Expended to Date**	**Current Provider**	**Alternative Service to be Provided after Transition**	**New Provider (if no change, indicate no change)**	**Effective** Date of **Transition**

I agree with the Services Transition Plan as established above and authorize my Care Coordinator to make referrals on my behalf to my chosen provider(s). I understand that if my chosen provider is unable to provide the service, my Care Coordinator will notify me and offer a choice of a different provider. A change in service provider selection will be made above in that event.

_____ _____
Client Signature Date

_____ _____
Care Coordinator Signature Date

Date Received: _____ ☐ Approved ☐ Denied

Comments:

ADAP Director _____ Date: _____